

Continuity of Care Advisory Panel  
October 4, 2013  
Meeting Minutes (1:00 – 4:00)  
Spring Grove Hospital Center (Dix Building)  
Agenda

- I. The meeting commenced at 1:00 pm in the basement of the Dix building after participants signed in on the designated workgroup sheet. Dr. Gayle Jordan-Randolph began with opening remarks indicating that we would have three presentations at today's meeting: (1) an update from the Data Workgroup; (2) a presentation on outpatient civil commitment; and (3) a presentation from the Legal Workgroup. Individuals who called in to the meeting were instructed to email Erin McMullen their contact information. Call in participants included: NaToya Mitchell (NAMI Maryland), Simon Powell (Department of Legislative Services), Scott Greene (Montgomery County Department of Health and Human Services), and Lynn Albizo (MAD-C). Dr. Jordan-Randolph indicated that following the presentation on outpatient civil commitment, there would be time for public comment and questions. The meeting will also include a period for public comment and questions regarding the Legal Workgroup's presentation.
- II. Data Workgroup Presentation (Zereana Jess-Huff, Michael Abrams, and Tim Santoni)
  - a. The workgroup presented the methodology it used to identify data from the Public Mental Health System (PMHS) and the Health Services Cost Review Commission (HSCRC). Ultimately high-end users were defined using high inpatient expenditures and/or a high number of emergency room visits (6 or more within a given year). There were approximately 500 consumers in each year included in this group.
  - b. Timelines for data requests from the Advisory Panel's workgroups were all disbursed. Data requests regarding the PMHS should be available first and HSCRC data should be available shortly thereafter.
- III. Outpatient Commitment Presentation (Joseph P. Morrissey, PhD)
  - a. Joseph Morrissey gave a powerpoint presentation on outpatient commitment. His presentation covered five key areas:
    - i. What is outpatient commitment (OPC)?
    - ii. Why is OPC so controversial?
    - iii. How strong is the evidence for OPC?
    - iv. Is OPC cost-saving?
    - v. Are there any options or alternatives to OPC?
  - b. A narrative report to accompany the slides will be provided to the Advisory Panel at a later date.

c. Public Comment and Questions

- i. Dr. Steve Daviss (Fuse Health Strategies) noted that if Maryland adopted an OPC program, it may reduce willingness for people to enter the PMHS in the first place. He asked whether there was evidence to support this. Joe Morrissey indicated that there has never been a systematic study to look at this.
  1. Dr. Daviss noted that the use of assertive community treatment (ACT) in New York, in addition to OPC, yielded some positive outcomes. How does this improvement compare to not having any ACT services?
  2. Joe Morrissey indicated that New York looked at 3 types of case management, including ACT. However, there was no subsequent analysis of what was accomplished by each form of case management. Of the total number of individuals in the New York study, only 30% got ACT, the rest got another form of case management. Results are not available for the different types of case management.
- ii. Brian Stettin (Treatment Advocacy Center) indicated that when New York was implementing its OPC law, he was an Assistant Attorney General at the time and was involved in the implementation of Kendra's Law. The notion that Kendra's Law is effective because of funding is a misconception because this issue is more complicated. New York is the one state that mandates that every county must have a OPC program. Each jurisdiction had to have the infrastructure to support the OPC population. Counties complained this was an unfunded mandated. Therefore, the money appropriated to this program was used to support infrastructure, not just services. There was a vast difference in how OPC programs were implemented in upstate New York vs. downstate. People downstate were more likely to be under a court order, and those upstate were not. There were differences in how people did downstate in regards to outcomes. Does a court order for OPC yield benefits/add value?
  1. Joe Morrissey noted that there was no evidence anywhere that a court order in and of itself is effective. ACT does produce positive outcomes in conjunction with a court order.
  2. Mr. Stettin noted that an individual cannot be committed to a program with no services.
- iii. Erik Roskes indicated that the information in the presentation highlighted outcomes in two states; however 45 states have OPC laws. The study from North Carolina resembles conditional release. This is different than what is done in New York. Why was the North Carolina program not considered conditional release?
  1. Joe Morrissey noted that the Duke Study was a random release study. People left without being under a court order. There was a separate court order when people were released into the community in North Carolina.
- iv. Lois Fisher (Office of the Public Defender) noted that if most of the money in New York went to support infrastructure, then funding that could have been used for services was wasted. There were two groups in New York, for those individuals that were not under a court order, the possibility of a court order was hanging over them. Ms. Fisher finds the term Assisted Outpatient

Treatment offensive, as it is not assistive. It is coerced. Have any states tried to pour money into services prior to implementing OPC?

1. Joe Morrissey indicated that he was unaware of any state doing this, at least not to the magnitude seen in New York. OPC legislation responds to urgency and public outrage/concern over isolated incidents. In theory, anyone is at risk for OPC. He does not believe that people were threatened with OPC to make them participate in treatment. This would mean there would be no difference at all between groups (those under court order, and those that participate voluntarily).
  2. Ms. Fisher noted that some people don't listen no matter what. Joe Morrissey reiterated that OPC and ACT yielded more positive results than ACT alone.
- v. Kait Roe (Fuse Health Strategies) asked for clarification regarding slide 19 of Mr. Morrissey's presentation. If findings are null and evidence is weak, how does a multivariate analysis create strong evidence?
1. Joe Morrissey explained that the multivariate analysis looked at individual encounters over a 12 month period. Taking data on a monthly basis creates 12 times the number of observations per individual. This gives you more information and allows you to view trends. It creates a richer source of information and a larger sample improves statistical significance.
  2. Kait Roe had additional questions regarding slide 11. Arguments against OPC seem less quantifiable. Is this a bias? Joe Morrissey noted that there was no effort to summarize points in pros and cons in unquantifiable ways. The arguments summarized on slide 11 are simply those that have been made.
  3. Ms. Roe also noted that studies reflect the Medicaid population and these studies can't be used to make generalizations of the total population.
- vi. Laura Cain (MDLC) asked if there were any studies to look at consistency/quality of providers of OPC services. Does OPC create motivation with providers?
1. Joe Morrissey noted he was unaware of studies that looked at this. He did note that clinicians' attitudes are a variable in OPC.
  2. Ms. Cain noted we have been talking about the lack of accountability in the system. Although the conversation regarding OPC has taken up a lot of time, we have identified disruptions to continuity of care. Does OPC prevent mass shootings? Swanson says no. After Sandy Hook, Swanson was stated those with serious mental illness, without any other risk factors, are as much of a threat as anyone else. People incorrectly state that mass shootings are a result of individuals whose mental illness has went untreated. Here in Maryland we do not use this type of fear mongering, unless there are studies that show this. Mr. Morrissey noted that these are rare unpredictable events. OPC won't categorically prevent these types of events.
- vii. Catherine Grey (Anne Arundel County Mental Health) asked what the impact of OPC was on homelessness?

1. Mr. Morrissey indicated that there are papers that deal with this. However, he could not give an exact answer to this question and will try to comment on it in the narrative to accompany today's presentation.
- viii. Linda Raines noted that if we could engage people, they would get better. This is true for most people. There is a small group of people that we don't have effective treatment for. Does any research look at this small subset of people? How can symptoms be ameliorated for those involuntarily committed? This factor needs to be considered.
  1. Mr. Morrissey responded that clinical treatment literature may be out there. Anything that outside of OPC was not in the purview of his presentation. However, he agreed that this is an important question. How big is this group of people? The size of the group will impact cost and dictate the type of system that Maryland needs. The original OPC statutes were done without these estimates.
  2. Ms. Raines asked if people fall into the OPC category because we don't have effective treatment. How would OPC help these individuals?
- ix. Howard Goldman (University of Maryland) – There is no inventory of state data on this topic. What do compulsory orders compel people to do? When we commit someone to inpatient care it doesn't necessarily mean you can compel them to utilize certain treatment. What states allow forcible medication? We don't know much about OPC, or compulsory treatment, or what it is.
  1. Mr. Morrissey agreed. There is information out there regarding what each state's OPC statute includes. However, just because a state has an OPC law, what actually happens on the community level suggests tremendous variability in OPC implementation. For instance, how are court orders applied or revoked? Many statutes don't have forced medication provisions. This requires a separate court decision.
- x. Dr. Jordan Randolph asked whether OPC is medically necessary. What is the medical necessity criteria? In the era of managed care, what does that mean? It sounds like OPC is fully funded by the state for the Medicaid population. Does this create further stigma because it is state funded based on legal criteria? Do other carriers acknowledge and reimburse for OPC? Services, such as ACT are very expensive.
  1. Mr. Morrissey was unsure. In studies, these are state patients. OPC is an alternative to inpatient commitment. Some would argue it is a less costly program than committing individuals to state hospitals. Data doesn't support this quite yet. He doesn't know what MCOs think about OPC. They probably wouldn't be eager to see OPC as medically necessary. He clarified that this was his opinion, not a fact.

#### IV. Legal Workgroup presentation (Margaret Garrett and Dr. Randall Nero)

- a. Ms. Garrett and Dr. Nero gave a powerpoint presentation on the Legal Workgroup's findings. This presentation covered the following legal barriers to continuity of care:
  - i. Housing
  - ii. Forced medication
  - iii. Confidentiality
  - iv. Advance directives

- v. Guardianship
- vi. Inpatient and outpatient involuntary commitment
- vii. Discharge planning and accountability from providers
- b. Comments from Workgroup Members and the Public
  - i. Dan Martin noted that there were problems with the workgroup's process. The workgroup's charge was to examine legal barriers to continuity of care. Mr. Martin noted that not enough time was spent discussing legal barriers. Rather the workgroup focused on statutes for things like OPC. He noted that he would of liked to spend more time identifying legal barriers.
  - ii. Laura Cain stated that there were members who didn't view some issues as legal barriers. We didn't get the opportunity to look at whether certain issues would withstand a legal challenge. With forced treatment, there was no examination of the sustainability of changing the statute. There were serious legal issues that the committee did not address. In part, this was due to the short time frame the workgroup was operating under. In regards to guardianship, Ms. Cain disagreed with the presentation; there wasn't consensus on this issue. The impact of forced treatment on trauma survivors impedes long term recovery.
  - iii. Kait Roe noted that she had concerns regarding the process. The first draft of the workgroup's presentation ignored the conversation in the group. Language used in the report is biased towards a belief that OPC is positive. This bias doesn't allow us to look at OPC from a legal standpoint. She was asked to attend legal workgroup meetings because people were in favor of forced treatment, and there was no patient participating in the conversation. This was not a balanced panel. There are legal barriers to continuity of care for individuals with serious mental illness. Ms. Roe does not feel like the workgroup looked at these barriers. We should take another look at actual legal problems regarding continuity of care.
  - iv. Evelyn Burton mentioned that the co chairs were open to the diverse comments of workgroup members. Everyone had their say in the discussion regarding forced treatment. Family members gave examples of legal barriers that prevent continuity of care. When people say anecdotal information can't be a basis for changing the law, people don't understand family involvement. NAMI receives many calls regarding this. Sometimes consumers have to be represented by family members due to suicide and incarceration. Ms. Burton recognized that forced treatment can lead to trauma. However, she asked the panel to recognize trauma for consumers who go untreated, and those in jail. Jail is traumatic. She urged the panel to be critical regarding studies of OPC. Are they peer reviewed? If they aren't peer reviewed studies, then they are merely someone's opinion. The article by Michael Rowe that was circulated is an editorial.
  - v. Ed Kelley stated that it is remarkable how compelling anger is regarding mental illness. He stated that he was surprised that stories shared by family members were called anecdotal. Not being able to get someone into a hospital is a problem. We shouldn't accept tragedy. Mr. Kelley noted that he has seen the mental health system at its worst and he appreciates the opposition, but believes that opposing sides need to come together. He appreciated that the

clinical workgroup noted that there are separate subgroups within the SMI population that need to be addressed separately.

- vi. Janet Edleman read testimony of a friend who wound up in jail. She was gravely disabled. Ms. Edleman was asked to submit her written testimony.
- vii. Lois Fisher commented that anecdotal evidence is accepted in lieu of less solid evidence. The workgroup didn't discuss legal barriers. The dangerousness standard is not a barrier to treatment. You can't pass legislation to address instances when doctor's do not understand what the dangerousness standard is. An ALJ broadly defines dangerousness as do doctors. A lot of people are frustrated and want the law to solve a problem that medicine hasn't been able to solve. Forced medication isn't a legal standard that holds up. Bad cases make bad law.
- viii. Giles Knight (NAMI, Montgomery County) Arguments regarding OPC is a disservice for everyone. What Mr. Kelley said is true, mental illness is scary. Mr. Knight provided a short summary of his son's battle with mental illness that included several hospitalizations and his son experienced homelessness. Since Maryland doesn't have OPC, the cycle in and out of hospital continues. The community doesn't take care of individuals with serious mental illness. Disciplined outpatient treatment is needed. There is no legal way to ensure medication is taken.
- ix. Elaine Carroll indicated that she empathizes with everyone. Ms. Carroll read the testimony of a consumer. After reading the testimony, she noted that she was unsure how the dangerousness standard was used in this case. Involuntary commitment should not be used. We need to work on implementing the laws we have, not create new incongruent laws. Ms. Carroll was asked to submit the testimony she read to the Panel.
- x. Mike Finkle (On Our Own) is opposed to the relaxation of commitment standards. Voluntary enhanced services is the answer, not coercive treatment. Mr. Finkle noted that he had submitted written testimony. He also indicated that the Surgeon General indicated that the need for coercion will reduce when services are available. Coercion is not a substitute for care.
- xi. Brian Stettin cited that he was saddened by the animosity. Where is the common ground? He believed he Ms. Fisher's testimony gave hope for a common ground regarding the dangerousness standard. However, Ms. Fisher noted that they disagreed on this topic. She believes that doctor's should be required to take continuing education credits around this issue.
- xii. Steve Daviss indicated that he was speaking as a physician, with a health IT background, and as a family member. The solution to this issue seems simple, if someone lacks capacity for informed consent, you get substituted consent for all other illnesses. Why can't we do that for people with mental illness? If there brain doesn't work, because of stroke, you can get a family member to provide informed consent. In regards to CRISP, behavioral health provider information isn't transmitted through the HIE. Rules that apply to behavioral health records are more complicated, but SAMHSA has software where information can be segmented and patients can agree to different levels of information sharing. In regards to the discussion of continuity of care for people who don't want treatment, we need to put effort into whether provider directories are

inadequate. We need transparent directories. Exchange directories are brand new, and they aren't right.

- V. Dr. Jordan-Randolph asked participants to email their testimony and comments to Erin McMullen. The meeting concluded at 4 pm. A final meeting of the full Advisory Panel will be scheduled at a date to be determined.

Prepared by: Erin McMullen